Appendix A

1. **Mental Health Association in Texas Fact Sheet on Suicide in Texas**
2. **White Paper on Suicide Prevention in Texas**
3. **Texas State Suicide Prevention Plan**

An Affiliate of the National Mental Health Association

Mental Health Association in Texas

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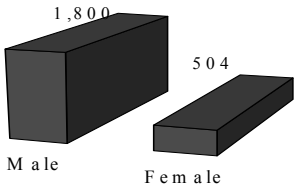
Suicide deaths are tragic and preventable.

- There are 1½ times more suicides than homicides with an average of **6 deaths each day** by suicide in Texas.
- Of the suicides carried out, **90%** are related to untreated or under-treated mental illness with the most common factor associated with suicide being depression.
- Nearly **20%** of the people diagnosed with bipolar disorder and **15%** diagnosed with schizophrenia die by suicide.
- **302** more people committed suicide in 2002 than in 1999—**a 13% increase in three years**.

Source: Texas Department of Health for 2002

Suicides by Gender in 2002



Source: Texas Department of Health for 2002

	Suicides by Young people less than 24 yrs in 2002	Suicides by Adults greater than 24 yrs in 2002	TOTAL Suicide deaths in 2002
Bexar	25	110	137
Dallas	29	201	230*
El Paso	5	48	53*
Harris	59	328	387*
Tarrant	16	105	121
Travis	13	97	110*
TEXAS	**346**	**1,955**	**2304***

* Indicates an increase in the total number of suicide deaths since 2001.
Source: Texas Department of Health for 2002

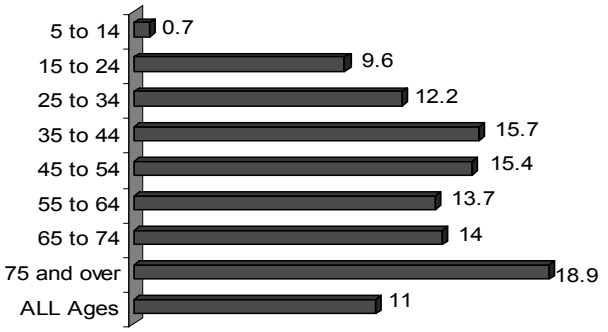
Nationally, there are twice as many deaths due to suicide than deaths due to HIV/AIDS.
National Institute of Mental Health

With the downturn in the economy, budget cuts, layoffs, and an ongoing war, more Texans than ever will benefit from suicide prevention.

- **24** children **below the age of 14** committed suicide in Texas in 2002. The incidence of suicide is increasing among children 10-14 yrs.
- **183** people **over age 75** in Texas committed suicide in 2002.
- **2,304** people committed suicide in Texas in 2002.
- The highest rates for suicide in Texas are among the 35-44 age group (15.7 per 100,000) and the 75 and over age group (18.9 per 100,000 people).

"There is no typical suicide victim. It happens to young and old, rich and poor."
American Association of Suicidology

Rate of Suicide by Age Group in 2002 (per 100,000 people)



Suicide Rates per 100,000 people in 2002

Source: Texas Department of Health for 2002

	5 to 14		15 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 and over		All Ages	
County	#	**Rate**	#	**Rate**	#	**Rate**	#	**Rate**	#	**Rate**	#	**Rate**	#	**Rate**	#	**Rate**	#	**Rate**
Bexar	2	*	23	10.3	31	14.3	18	8.3	27	14.7	11	9.6	13	16.3	10	14.4	137	9.6
Dallas	3	*	26	7.8	41	9.8	53	14.5	51	18.2	33	19.8	13	13.2	10	12.1	230	10.7
El Paso	0	*	5	4.4	13	12.7	11	11.0	10	12.2	7	13.6	2	*	5	17.2	53	8.3
Harris	2	*	57	10.9	76	12.5	94	16.7	78	16.7	35	13.1	20	13.4	25	22.1	387	11.6
Tarrant	1	*	15	6.8	18	7.3	35	13.9	21	10.3	14	11.8	12	17.4	5	8.8	121	8.3
Travis	0	*	13	8.8	26	15.4	23	16.7	23	21.4	14	25.7	8	26.2	3	*	110	13.6
Texas	**24**	**.7**	**322**	**9.6**	**401**	**12.2**	**530**	**15.7**	**435**	**15.4**	**242**	**13.7**	**164**	**14.0**	**183**	**18.9**	**2,304**	**11.0**

* Indicates numerator too small for rate calculation. Source: Texas Department of Health for 2002. Rates are calculated based on the incidence per 100,000 people.

WHITE PAPER ON SUICIDE PREVENTION IN TEXAS

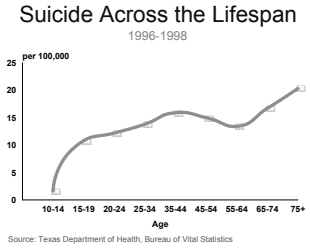
Suicide has been identified as a public health problem by the Surgeon General of the United States. This paper proposes that suicide is also a public health problem in the State of Texas. It is one that needs a statewide response as it is receiving a national response. It is a problem for citizens of all ages and among all groups. It is a problem for the teenager who appears successful but whose inner life is black with despair. It is a problem for the counselor whose client has committed suicide. It is a problem for family members when their grandfather shot himself to death. It is a problem for the family of the teenager who has been talking about suicide and who feels especially distant one day. It is a problem for the policeman who has shot someone and finds that the dead subject was threatening with a toy pistol. It is a problem for the school when a loved student has just hanged himself. It is problem for us all.

I. Suicide as a Public Health Problem in Texas

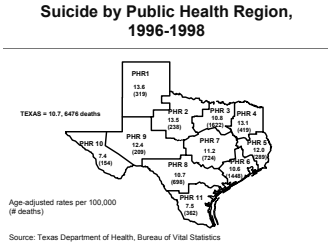
A. Data

The available data indicate that suicide ranks among Texas' most pressing health problems:

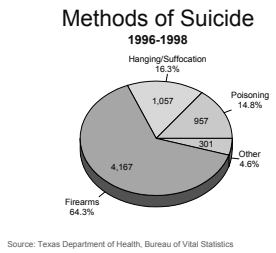
- Suicide took the lives of 2,002 Texans in 1999.[1]
- More Texans died from suicide than homicide. In 1999, there were 1.5 times as many suicides as homicides.[2]
- Suicide is the 8th leading cause of death in the state, and the third leading cause of death for young Texans (aged 15 – 24). [3]
- Texans under age 25 accounted for 15% of all suicides in 1999.[4]
- Texas suicide rates have been fairly stable since 1980, ranging from 11 to 13 deaths per 100,000 population.[5]
- Risk factors for suicide among older persons differ from those among the young. Older persons have a higher prevalence of depression, a greater use of highly lethal methods, and social isolation. [6]



Suicide rates increase with age



Suicide rates are higher in rural areas



Most suicide deaths for all age groups are by firearms

2. Attempts and Ideation

Though some information is known on completed suicides, data on suicide attempts in the state are remarkably scarce.

- Estimated 53,000 attempts annually.[7]
- Over 3,000 self-inflicted injuries were identified in Texas hospital discharge data for first half of 1999.[8]
- Among Texans less than 20 years, estimated 5,000 non-fatal attempts are medically treated annually.[9]

3. Economic costs

- Estimated at nearly $1.4 billion for Texans less than 20 years.[10]

II. What has been done to address the Problem?

A. Community Level

Without a resource book of services available for suicidal and mental health issues, it is difficult to know of or discuss the suicide prevention efforts that are being made across the state. There are a number of scattered school and community based programs, organizations, and coalitions with efforts designed to reduce suicidal behavior. The most common efforts include crisis centers and school crisis programs and/or educational trainings for adults ('gatekeepers') or peers. These programs are usually targeted towards at-risk youth populations.

The efficacy of suicide prevention and intervention programs has not yet been firmly demonstrated. One aspect of this is that programs are developed and implemented which are designed to change *knowledge* about suicide, but are often without sufficient evidence they reduce suicidal *behavior*. It is important to use evidence-based approaches to suicide prevention and make efforts to research and identify approaches that reduce suicidal behavior and ideation. Also, clinicians working with potentially at-risk clients often have little or no formalized training regarding suicide. Coursework for college degrees and professional certification are generally lacking training in identifying and intervening with suicidal clients.

B. State Level

The 71st Texas Legislature passed several bills regarding suicide prevention. House Bills 2321 and 2322 direct the Texas Education Agency's (TEA) involvement with youth suicide prevention. These legislative efforts require TEA to furnish guidelines to larger school districts and appropriate local agencies (i.e., police, mental health centers) for establishing cooperative youth suicide intervention procedures and directs the TEA commissioner to create an advisory committee on youth suicide prevention. The committee's purpose will be to provide advice and assistance to other agencies and schools to develop and implement policies, procedures and programs to

prevent youth suicide. Additionally, House Bill 2382 directs the Department of Mental Health and Mental Retardation to designate a youth suicide prevention officer to serve as liaison to the Texas Education Agency. House Concurrent Resolutions 266 and 29 encourage the State Board of Education to provide in-service training on suicide prevention and intervention and prescribes content for such.

In order to address the legislation, Texas Education Agency established guidelines for school districts for the creation and training of crisis intervention teams. A Youth Suicide Prevention Advisory Committee was appointed in 1989-90 by the Commissioner of Education. Training of Trainers began in 1990 for all school personnel in each of the Regional Education Service Centers on suicide prevention, intervention in teacher in-service training and preparation. While all of the directives of the 71st Texas Legislative were addressed by the Texas Education Agency, the impact of these efforts is difficult to notice. Although the suicide rates for teenagers didn't increase 30% during the 1990s as they did during the previous decade, there was also little appreciable decline until the most recent years.

C. National Level

Suicide prevention has traditionally been an area that the federal government has steadfastly ignored. In recent years, however, a national need for suicide prevention has been recognized. In a rare instance of public and private collaboration the federal government worked with a suicide prevention advocacy group to sponsor a 1998 conference in Reno, Nevada. The 3 days featured experts in the field presenting the scientific knowledge about suicide and discussing the implications for a national suicide prevention strategy. The outcome of this conference is "The Call to Action to Prevent Suicide" issued from the office of the Surgeon General. This report proposes that the nation and states adopt a prevention strategy encompassing 3 central components: Awareness, Intervention, and Methodology (AIM). From this framework came specific goals and objectives, which are listed and discussed in The National Strategy for Suicide Prevention, published in May 2001. States are encouraged to adopt and adapt the National Strategy for implementation at the state and community levels. Eighteen states have developed and implemented suicide prevention plans. To date, Texas has not.

III. What needs to be done?

A. Suicide Prevention with Public Health Model

A well-coordinated, comprehensive response to suicide is absent in most of the state. The previous legislation regarding suicide prevention targeted a narrow population (schoolchildren) and from a limited perspective (education and crisis intervention in schools). While this is a necessary component of a well thought prevention plan, it does not provide the necessary breadth and scope. Suicide is a complex phenomenon with risk increasing or being prevented through an interaction of biological, psychological, social, and environmental factors. An effective plan must utilize knowledge and resources in a coordinated fashion to intervene through an interdisciplinary perspective directed towards individuals, families and peers, and communities for people of all ages.

This social ecological perspective is often incorporated in the public health model of prevention. This model entails initiating activities to learn more about the incidence and circumstances of suicidal behavior, identifying, developing, and implementing suicide prevention and intervention programs, and evaluating these efforts. This model is further defined by its identification of three levels of prevention: (1) Primary, in which

efforts are made to increase resiliency and identify potentially at-risk people prior to becoming suicidal; (2) Secondary, in which intervention occurs after a person exhibits suicidal warning signs; and (3) Tertiary, involving interventions after a person has attempted suicide or experienced a death by suicide in their community. Each of these levels is necessary for a successful prevention effort, but none is sufficient in and of itself.

B. Texas Statewide Strategic Plan for Suicide Prevention

It is encouraged that Texas follow the National Strategy for Suicide Prevention put forth by the U.S. Surgeon General in May, 2001. This strategy utilizes a multidisciplinary approach and proposes 3 components of a comprehensive plan: Awareness, Intervention and Methodology.

Awareness

This component involves raising public and professional awareness and support to understand suicide as a preventable public health problem. This includes education about protective and risk factors, dispelling myths surrounding suicide, and developing broad based support for collaborative prevention efforts. Additionally, efforts to reduce the stigma revolving around suicide and the associated mental health and substance abuse issues must be implemented.

Intervention

As noted earlier, there are 3 levels of prevention within a public health model. Evidence based services and programs for suicide prevention should be implemented at each of these levels and the necessary training and education for community-based implementation of these services should be provided. The barriers to receiving these and mental health and substance abuse services need to be addressed and eliminated.

Methodology

There is a large void of information regarding the incidence and circumstances of suicidal behavior. While there are reasonable estimates of the number of suicide deaths, there is dearth of information about the circumstances surrounding the suicide death or about suicide attempts and ideation. This is the information vital for prevention efforts. Mechanisms for systematic, statewide data collection need to be developed and implemented.

It is important to note that such a plan involves a coordinated response across disciplines and levels. Services aimed at mental health and substance abuse issues must be interwoven with efforts in the education, health care, social service, and criminal justice professions. The comprehensive nature of the plan will also have need of the commitment of the private sector, including business and labor. Effective programming must entail close collaboration between state and local agencies. Local communities can be best supported through a close relationship with state agencies and policy makers. Such a comprehensive and coordinated response to this issue can result in improving and saving the lives of many Texans.

Summary

On average, more than 6 people die from suicide every day in Texas. Countless times that number attempt suicide or are debilitated by suicidal thoughts. The cost to our society is staggering. Yet there has been little effort directed to this enormous problem. The federal government, recognizing the public health nature of this problem, has created a national strategy for intervention and has called upon individual states to respond. Nearly half the states have either developed a statewide strategic plan for suicide prevention or are in the process of doing so. Texas is joining this effort through the work of a grassroots committee comprised of professionals and interested individuals from a variety of disciplines, levels of involvement, and geographic areas of the state. This committee is creating a comprehensive, coordinated suicide prevention plan for the state. It is time for the state legislature to recognize the need for action and form a sustainable and functional operating structure for complete development and implementation of this plan.

(UPDATE: This white paper was written by members of the Texas State Suicide Prevention Steering Committee in 2002. In 2001, the Speaker of the Texas House of Representatives charged the House Human Services Interim Committee to study the issue of suicide prevention in Texas. The Interim Report was done and is available online. In addition, members of the steering committee finalized the Texas State Plan for Suicide Prevention. Since then, all states now either have a state plan for suicide prevention or are in the process of developing one.)

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A SUICIDE PREVENTION PLAN FOR TEXAS: HISTORY AND BACKGROUND

A Suicide Prevention Plan for Texas is a part of a process that began in 1999 when the United States Surgeon General published a Call to Action to Prevent Suicide. This call declared suicide to be a national public health problem. The program proposed action in three areas: Raised Awareness, Enhanced Intervention Programs, and Improved Methodology for research and service evaluation.

The second phase ended in 2001 when the Surgeon General's office published: National Strategy for Suicide Prevention: Goals and Objectives for Action. One element of this strategy is the development of Suicide Prevention Plans in the states.

In June, 2001, a Texas effort began with a Texas Suicide Prevention Forum held in Austin and sponsored by the Governor's Emergency and Trauma Council and the Texas Department of Health. In the fall of 2001, a Steering Committee began meeting and completed a Draft Suicide Prevention Plan in June, 2002. The Texas Plan is closely modeled after the National Strategy. The plan focuses on suicide prevention as a concern for all age groups. You can also access the Plan on the following web site.

http://groups.yahoo.com/group/TxSuicidePreventionGroup
Enter site. Open: "Files"

In 2001, the Speaker of the Texas House of Representatives charged the House Human Services Interim Committee to study the issue of suicide prevention in Texas. In their report, the committee recommended that the Legislature establish a Suicide Prevention Council to design and implement a comprehensive statewide suicide prevention plan. The full text of their study report and recommendations can be read at the Texas House Web Site for Interim Reports (click on the Human Services) section below.

http://www.house.state.tx.us/committees/reports/77interim/welcome.htm

Beginning in January, 2002, Community Listening Meetings were held across the state to allow stakeholders, government officials, and citizens to be educated about the Draft Plan and to give input to this plan.

The Surgeon General's office released the National Strategy for Suicide Prevention: Goals and Objectives in May, 2001, calling on all states to develop a state plan following the national guidelines. This national call to action came from a private/public cooperative effort to address the critical public health issue of suicide. During this same time period, a group of concerned Texas citizens and professionals gathered from around the state to meet in Austin to discuss a coordinated, statewide effort for suicide prevention. This meeting resulted in a statewide private/public effort to begin to understand where we are and where we need to go for suicide prevention in Texas. The attendees of this meeting asked for a coordinated, comprehensive suicide prevention plan for our state.

In response to the state call to action, a multi-disciplinary group of professionals and survivors held a meeting in October, 2001, and created the Texas Suicide Prevention Plan Steering Committee. Members of the committee represented the mental health, medical, public health, aging, substance abuse, corrections, and education fields from a

variety of perspectives, including state agencies, local school districts and universities, clinical providers, and suicide survivors. The committee charged itself with creating a plan. Based on the National Strategy from the Surgeon General, the Texas Plan for Suicide Prevention lists goals, objectives, and strategies to address the varied aspects of suicide.

The key underlying idea of the Plan is that it is intended to be community-based. Agencies, organizations, businesses, educators, health providers and individuals acting in a coordinated effort are most capable of assessing community needs regarding suicide prevention and implementing the necessary interventions at a local level with the support and coordination from the state.

Clarification of a few key terms and the distinctions made are included below. Contributors to the plan agreed that the 3 terms, 'mental health,' 'mental illness,' and 'mental disorder' are generally synonymous, with each term carrying its own connotation and implication. Therefore, the Proposed Texas Suicide Prevention Plan uses the terms in specific contexts. 'Mental health' is the general term to be used, except when addressing treatment issues or issues with treatment implications; 'mental illness' is used in these situations.

There were similar discussions regarding 'best practice' and 'evidence-based' interventions. By definition, programs or activities that are referred to as being one or the other must have evidence of effectiveness, with 'evidence based' requiring a more stringent level of scientific support (see glossary). While this higher level of scientific thoroughness is desired, there are few current interventions that meet these criteria. Therefore, the Plan includes 'best practice' activities, with the understanding that these activities will now include a thorough scientific component to enable program effectiveness to be determined.

Implicit throughout the plan is the need for assessment and evaluation. While it may or may not be listed, the starting point for many of the strategies is to determine what materials and resources are already available. And as noted above, there is a need for more and better science about suicide prevention. Intertwined throughout most of the suggested strategies is the need to evaluate the process and the outcomes. Sound evaluation of programs will build the evidence base and ensure that the few and precious suicide prevention resources available will be directed toward those activities that can demonstrate effectiveness.

Texas State Plan for Suicide Prevention:

GUIDELINES FOR SUICIDE PREVENTION IN TEXAS

AWARENESS GOALS, OBJECTIVES AND STRATEGIES

Goal 1. Promote Awareness that Suicide is a Public Health Problem that is Preventable

Objective 1.1. Increase cooperation and collaboration between and among both public and private local and state institutions that have made a commitment to public awareness of suicide and suicide prevention.

Strategies

1.1.1. Establish a network of public and private local and state institutions who communicate regularly via internet and regular state meetings.

1.1.2. Provide material that promote awareness of suicide as a preventable public health concern that can be distributed within communities by the network of public and private local and state institutions.

Objective 1.2. Establish regular state symposiums on suicide prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.

Strategies

1.2.1. Adopt a state-wide resolution by the governor to the concept of a "day" within the national suicide prevention week each September.

1.2.2. Coordinate an annual symposium to support awareness and/or prevention.

Objective 1.3. Increase the number of counties in which public information campaigns are designed to increase public knowledge of suicide prevention.

Strategies

1.3.1. Develop and run public service announcements distributed to local community television and/or radio stations.

1.3.2. Develop bi-annual billboard advertising with a community phone number and/or web site.

Objective 1.4. Increase the number of both public and private local and state institutions active in suicide prevention that are involved in collaborative, complementary dissemination of information on the world wide web as well as by other means.

Strategies

1.4.1. Develop a web site to disseminate suicide prevention activities and efforts.

Goal 2. Develop Broad-Based Support for Suicide Prevention

Objective 2.1. Identify and support a management/leadership structure for the oversight of the Texas Suicide Prevention Plan.

Strategies.

2.1.1. Establish a Suicide Prevention Council representing a broad spectrum of agencies, institutions and groups to oversee implementation of the Texas Suicide Prevention Plan

2.1.2. Establish a new position of Director of Suicide Prevention, including a staff of a Program Specialist, Health Educator and Administrative or Public Health Technologist.

Objective 2.2. Establish a public/private partnership(s) with the purpose of advancing and coordinating the implementation of the Texas Suicide Prevention Plan.

Strategies

2.2.1. Blend resources of stakeholders to increase broad based support for suicide prevention.

2.2.2. Utilize broad based support to seek additional funding.

Objective 2.3. Increase the number of local, state, professional, voluntary and faith-based groups that integrate suicide prevention activities into their programs.

Strategies

2.3.1. Develop a plan to educate local, state, professional, voluntary and faith-based organizations about the importance of integrating suicide prevention activities into their programs.

2.3.2. Distribute specific suggestions and examples of integration.

Goal 3. Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse and Suicide Prevention Services.

Objective 3.1. Increase the proportion of Texans who view mental and physical health as equal and inseparable components of overall health.

Strategies

3.1.1. Increase the availability of information (brochures, public service announcements, conferences, presentations) across the state that includes and/or supports the message that mental health is fundamental to health.

3.1.2. Target at-risk populations for mental health public education and information campaigns.

Objective 3.2. Increase the proportion of Texans who view mental health issues as illnesses that respond to specific treatments.

Strategies

3.2.1. Use opinion editorials, public service announcements, and spokespersons to articulate the message that mental illnesses respond to effective treatment.

3.2.2. Educate health care professionals, particularly in primary care, to increase their ability to appropriately identify mental health illness in their patients.
3.2.3. Encourage mental health professionals to promote strategies to impact citizen perception that mental health issues are illnesses that respond to specific treatments.

Goal 4. Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media.

Objective 4.1. Promote the accurate and responsible representation of suicidal behaviors, mental illness and related issues in the media.

Strategies

4.1.1 The Suicide Prevention Advisory Council will acknowledge the accurate and responsible representation of suicidal behaviors, mental illness and related issues in the media.

Objective 4.2. Increase the proportion of news reports on suicides in Texas that observe consensus reporting recommendations.

Strategies

4.2.1. Establish a process for the collection and analysis of news reports on suicide in Texas.
4.2.2. Encourage Texas journalism schools and media associations to adopt the recommendations for reporting suicide of the American Association of Suicidology, et. al. and develop a strategy for dissemination of the recommendations to key media.

Objective 4.3. Increase the number of journalism schools in Texas that include in their curricula guidance on the portrayal and reporting of mental illness, suicide and suicidal behaviors.

Strategies.

4.3.1. Convene meetings with Texas journalism schools and media associations to discuss the American Association of Suicidology reporting recommendations regarding suicide and develop a strategy for dissemination of the recommendations and their presentation in curricula.

INTERVENTION GOALS AND OBJECTIVES AND STRTEGIES

Goal 5. Develop and Implement Community-Based Suicide Prevention Programs.

Objective 5.1. Increase the proportion of public school districts and private school associations with best practice based programs designed to address mental illness and prevent suicide.

Strategies

5.1.1. Survey districts for existing programs including: a) school policy or operating procedures, b) training for counselors, social workers, psychologists, nurses and general staff and c) provision for post-suicide completion crisis counseling and procedures.

5.1.2. Revise and update guidelines for school suicide prevention programs and make them available to all Regional Service Centers.

5.1.3. Include suicide prevention protocols in legal school policies disseminated by the Texas Association of School Boards.

5.1.4. Promote early prevention programs within student support services including: a) mentoring, b) peer mediation and conflict resolution, c) anger management, d) life skills and character education, e) substance abuse, and f) parent involvement.

5.1.5. Support the inclusion of suicide prevention through the local school health curriculum.

5.1.6. Encourage school districts to request guidance for their suicide prevention programs from their local school health advisory committees.

Objective 5.2. Increase the proportion of colleges and universities with best practice based programs designed to address mental illness and prevent suicide.

Strategies

5.2.1. Survey Texas colleges and universities for existing programs including: a) policy or operating procedures, b) training for physicians, psychiatrists, psychologists, counselors, social workers, nurses and general staff and c) provision for suicide postvention counseling and procedures.

5.2.2. Promote guidelines for suicide prevention, intervention and postvention programs and make them available to all college and university counseling/student health departments, chaplains, etc.

5.2.3. Include suicide prevention protocols in legal school policies and in faculty handbooks.

5.2.4. Promote early prevention programs including provision of extensive student support services and comprehensive mental and physical health student and faculty-centered health promotion education strategies.

5.2.5. Promote the education of all campus personnel on identification, intervention and referral of early symptoms of mental distress in students and staff.

5.2.6. Test and promote programs to train faculty and resident staff to train students to identify and refer students at risk for suicide.
5.2.7. Promote a program that trains campus personnel to identify and refer potential students at risk.

Objective 5.3. Increase the proportion of employers that ensure the availability of best practice based prevention strategies for suicide.

Strategies

5.3.1. Promote training through the appropriate professional organizations such as the Texas Workforce Commission, Employee Assistance Programs, Society for Human Resources, and the Chambers of Commerce.

Objective 5.4. Maintain the proportion of correctional institutions, jails and detention centers housing either adult or juvenile offenders with best practice based suicide prevention programs.

Objective 5.5. Increase the proportion of aging networks that have best practice based prevention programs designed to identify and refer for treatment of elderly people at risk for suicidal behavior.

Strategies

5.5.1. Promote the implementation of best practice prevention programs throughout the Aging Network.
5.5.2. Provide support and technical assistance to the Aging Network.
5.5.3. Increase outreach to older adults and encourage screenings for depression, substance abuse and suicide risk with emphasis on rural areas.
5.5.5. Encourage continued partnerships between aging network and mental health providers.

Objective 5.6. Increase the proportion of family, youth and community service providers and organizations with best practice based suicide prevention programs.

Strategies

5.6.1. Provide links to schools and local health departments for community providers capable and interested in assisting with the implementation of the programs.

Objective 5.7. Promote training and technical assistance for suicide prevention programs through the Suicide Prevention Advisory Council utilizing best-practice guidelines.

Strategies

5.7.1. Promote a packaged education program that can be implemented by community workers. Incorporate information specific to high-risk populations.
5.7.2. Promote training for community providers in implementation of the educational program.

Objective 5.8. Ensure that an evaluation component is included in all suicide prevention programs.

Goal 6. Promote Efforts to Enhance Safety Measures for Those at Risk of Suicide.

Objective 6.1. Increase the proportion of primary care clinicians, other health care providers, and health safety officials who routinely assess safety practices and educate about actions to reduce associated danger for those at risk for suicide.

Strategies

6.1.1. Encourage Texas Medical Association, Texas Society of Psychiatric Physicians, Texas Department of Insurance and Mental Health/Mental Retardation Agencies as well as other medical societies to review the quality and increase the availability of mental health continuing medical education.

6.1.2. Survey current practices used by primary care physicians, health care providers, health and safety officials to assess the presence of lethal means in the home.

6.1.3. Develop a safety assessment and education plan that can be implemented in five minute models. Pilot the use of these modules and disseminate the use of these modules through conferences and publications.

Objective 6.2. Increase the proportion of households exposed to public information campaigns designed to enhance safety skills in the home where a resident is at risk for suicide.

Objective 6.3. Develop guidelines and provide training for health care professionals for safer dispensing of medications for individuals at heightened risk of suicide.

Strategies

6.3.1. Support continuing medical education which assists physicians and other health care professionals in making appropriate clinical judgments when prescribing potentially lethal medications to patients at risk for suicide.

Goal 7. Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment.

Objective 7.1. Define the minimum course objectives in identification and management of those at risk for suicide and promotion of protective factors in each of the following professions: medicine, nursing, dentistry, social work, physical, speech and occupational therapy, psychology, law enforcement, EMS, law, pastoral care, education, first response, and other fields as appropriate.

Strategies

7.1.1. Review research and curricula materials available from the field of suicidology to establish a baseline standard for training in suicidology relevant to the professional focus of existing programs.

7.1.2. Develop guidelines for suicide prevention course objectives for each of the above licensing and certification boards.

Objective 7.2. Increase the number of re-certification or licensing programs in relevant professions which provide training in suicide assessment, management and prevention.

Strategies

7.2.1. Identify suicide prevention curricula mandated by licensing and certification boards in the above professions.

7.2.2. Form a small group of professionals from each of the relevant groups to advise, collect data by survey or other means on the current suicide prevention curricula incorporated in current licensing criteria.

7.2.3. Work with the Joint Accreditation Commission for Hospital Organizations, Texas Department of Health and Human Services, Texas Medical Association, and Texas Hospital Association to incorporate suicide management assessments into in-service training and report the results.

Objective 7.3 Increase the number of schools that include the suicide course objectives. Encourage direct clinical experience in the application of suicide prevention strategies in pre-professional education or at the graduate and postgraduate or employee level.

Strategies

7.3.1. Survey all schools and colleges of nursing in the state to identify curricular threads teaching suicide prevention.

7.3.2. Review curricula materials available from the field of suicidology to establish a baseline standard for training in suicidology relevant to the professional focus of existing programs.

7.3.3. Develop a sample curriculum for suicide education in undergraduate and graduate programs and distribute to all relevant schools and colleges for both mental health and non-mental health faculty.

7.3.4. Develop a pilot site to implement a plan for increasing the proportion of health professionals trained in suicide risk management. Seek un-restricted education grants.

7.3.5. Survey all schools two years after the distribution of the curriculum to see if any further action is being taken in providing appropriate suicide prevention education.

7.3.6. Work through the Texas Hospital Association to encourage all institutions to provide in-service training on suicide prevention to their professional staff.

7.3.7. Require annual staff development on awareness of suicide warning signs, agency policy and operational procedures, and general principals of suicide prevention for other institutions that work closely with young people and older adults.

Objective 7.4 Increase the number programs that train support personnel which include how to identify suicide risk factors, ideation, behaviors and appropriate referral strategies. These positions include but are not limited to paraprofessionals and other health care support personnel such as: nurse's aides, food service workers, maintenance, teacher aides, dental technicians, paralegals, correction officers,

social worker aides, funeral directors, "gatekeepers" such as hairdressers and bartenders, and workers from other agencies.

Strategies

7.4.1. Identify minimum course objectives in orientation and training programs for support personnel and volunteers in the relevant specialties.
7.4.2. Develop guidelines for the minimum course objectives needed for this group.
7.4.3. Use the same professional committee above to survey the certification and training programs of paraprofessionals in their fields that include knowledge of identification and referral of suicidal clients.
7.4.4. Work closely with the various boards that certify these workers to include objectives in suicide identification and referral in mandatory training programs and continuing education.
7.4.5. Develop brief sample curricula to be used as an example for each group of caregivers and support personnel.
7.4.6. Survey these training programs in three years to see the increase in the number of programs that are teaching these principles.

Objective 7.5 Develop suicide prevention awareness material and conduct training for community self-help groups.

Goal 8. Develop and Promote Effective Clinical and Professional Practices

Objective 8.1. Increase the proportion of patients who are treated for self-destructive behavior in hospital emergency departments that pursue an appropriate mental health follow-up plan.

Strategies

8.1.1. Develop funded grant support for research studies comparing standard practices versus enhanced follow-up.
8.1.2. Support best practice guidelines for follow-up plans.
8.1.3. Support community based programs for mental health follow-up.

Objective 8.2. Support the development of guidelines for assessment and management of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers. Implement these guidelines in a proportion of these settings.

Strategies

8.2.1. Encourage the use of guidelines for the assessment and management of suicide risk.

Objective 8.3. Increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behavior among their patients.

Strategies

8.3.1. Work with the appropriate licensing agencies to incorporate suicide management practices in facility assessments and report the results.

Objective 8.4. Support and encourage guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities.)

Strategies

8.4.1. Work with the Joint Accreditation Commission for Hospital Organizations and the Texas Department of Health and Human Services on incorporating suicide management practices in facility assessments and reporting the results.

8.4.2. Provide aftercare service to individuals who are still at risk for suicide or who maintain a significant level of suicidal ideation.

8.4.3. Include aftercare procedures in guidelines for licensed social service agencies serving individuals who are at risk for suicide.

Objective 8.5. Increase the proportion of those who provide key services to suicide survivors (e.g. emergency medical technicians, firefighters, law enforcement officers, funeral directors, clergy, mental health professionals, health care professionals) who have received training that addresses the service provider's exposure to suicide and the unique needs of suicide survivors.

Strategies

8.5.1. Encourage the use of best practice materials and programs for service provided to survivors of suicide.

8.5.2. Develop a liaison between the Texas Critical Incident Stress Management Network and the Suicide Prevention Council to assure that the first responders are being debriefed and supported as survivors as well.

8.5.3. Work with the state professional organizations of clergy, funeral directors and health care providers to raise awareness of the danger of exposure to suicide.

8.5.4. Develop and share a model curriculum for continuing education courses within each of the professional organizations.

Objective 8.6. Increase the proportion of patients with psychiatric mood disorders who complete a course of treatment or continue maintenance treatment as recommended.

Strategies

8.6.1. Support continuing medical education which emphasizes the importance of treatment continuance and maintenance, as appropriate, to prevent mental illness relapse.

8.6.2. Require health plans to pay for continuous and maintenance treatments for mental health disorders as supported by the standards for best practice.

8.6.3. Promote adherence to best practice standards for treatment of patients with mood disorders.

Objective 8.7. Increase the proportion of hospital emergency departments that routinely provide post-trauma psychological support, risk assessment when appropriate, and mental health education for all victims of sexual assault and/or physical abuse.

Strategies

8.7.1 Solicit funding for a conference on best practices and disseminate findings.

Objective 8.8. Support guidelines for providing suicide prevention education to family members and significant others of persons receiving care for the treatment of mental health, substance abuse disorders, and victims of assault and trauma. Encourage the use of guidelines in facilities (including general and mental hospitals, mental health clinics, and substance abuse treatment centers.)

Objective 8.9. Encourage periodic screening for depression, substance abuse and suicide risk in primary care settings, hospice, and nursing facilities for all heath care programs.

Goal 9. Increase Access to and Community Linkages with Mental Health and Substance Abuse Services

Objective 9.1. Require health insurance plans to cover mental health and substance abuse services on par with coverage for physical health.

Objective 9.2. Increase the proportion of rural and urban counties (or appropriate jurisdictions) with health and/or social services outreach programs for at-risk populations that incorporate mental health services and suicide prevention.

Objective 9.3. Promote and encourage guidelines for mental health screening and referral of students in schools and colleges. Implement those guidelines in a proportion of public and private schools and colleges.

Strategies

9.3.1. Promote and encourage an in-service training of all faculty and staff on how to recognize the signs of a student in suicidal crisis and how to refer that student to the proper available facilities for intervention.

9.3.2. Promote and encourage training of all college faculty and staff, especially those working in resident life, that includes how to recognize the signs of a student in suicidal crisis and develop a standard procedure on intervention.
9.3.3. Promote and encourage the use of a postvention training program for schools and colleges that illustrates how to work with students who were in crisis and those students who have been exposed to a suicide.

Objective 9.4. Promote and encourage guidelines for schools on appropriate linkages with mental health and substance abuse treatment services and implement those guidelines in a proportion of schools.

Strategies

9.4.1. Refer all students who are assessed as high risk for attempting suicide or those who have made a suicide attempt to a health care professional for further evaluation and treatment.
9.4.2. Provide continuous in-service training for school counselors and other school mental health care-givers on community referral resources.
9.4.3. Foster a linkage between the schools and community resources.

Objective 9.5. Encourage school-based clinics to incorporate mental health, suicide, and substance abuse assessment and management into their scope of activities.

Strategies

9.5.1. Work through the Texas Education Agency and the Texas Department of Health Adolescent and School Program to encourage schools to provide mental health, substance abuse and physical health services through school based clinics in conjunction with local resources.

Objective 9.6. Promote guidelines for adult and juvenile incarcerated populations for mental health screening, assessment and treatment of suicidal individuals.

Strategies

9.6.1. Encourage continuing training for all law enforcement personnel which addresses intake screening, suicide assessment, and emergency procedures.

9.6.2. Promote policies which establish consistent suicide watch levels, supervision, and intervention.

Objective 9.7. Promote guidelines for effective comprehensive support programs for suicide survivors.

Strategies

9.7.1. Encourage annual reviews of survivor suicide groups by mental health professionals.

9.7.2. Support policies that require survivors providing peer to peer support be recommended by physician or mental health professional and be 1 year past the suicide death.

Objective 9.8. Promote quality care/utilization management guidelines for effective response to suicidal risk or behavior and continuity of care guidelines.

Objective 9.9. Promote certification of crisis centers in Texas by the American Association of Suicidology.

Objective 9.10. Promote stronger linkage between crisis centers and mental health and substance abuse services.

Strategies

9.10.1. Strengthen linkage through sharing information regarding services.

9.10.2. Encourage service provider coalitions and provider groups to enter into mutual understandings with community mental health and substance abuse services.

9.10.3. Encourage collaboration for provision of services to eliminate duplication and ensure coverage.

9.10.4. Encourage the development of resource and referral guides for distribution and advertise the linkage and referral services.

9.10.5. Encourage the training of staff and volunteers of crisis centers on information regarding referral agencies and how to access them.

METHODOLOGY: GOALS, OBJECTIVES AND STRATEGIES

<u>Goal 10. Promote and Support Research on Suicide and Suicide Prevention.</u>

Objective 10.1. Develop a suicide research agenda.

Strategies

10.1.1. Conduct detailed epidemiologic studies of suicide and suicide attempts.

10.1.2. Review scientific evaluation studies of new or existing suicide prevention, intervention and postvention efforts.

10.1.3. Obtain input from survivors, practitioners, researchers and advocates.

10.1.4. Collect and analyze population-based information.

Goal 11. Improve and Expand Surveillance Systems.

Objective 11.1. Develop standardized protocols for death scene investigations and implement these protocols in all Texas counties.

Strategies

11.1.1. Assess and inventory current practices.
11.1.2. Develop a protocol model that is appropriate for persons of all age, gender, racial/ethnic groups.
11.1.3. Disseminate the protocol and arrange for training.
11.1.4. Develop timely reporting systems to identify suicide behaviors connected by person, place, or time to prevent contagion.

Objective 11.2. Increase the proportion of hospitals (including emergency departments), EMS, medical examiners, and law enforcement departments that collect uniform and reliable data on suicidal behavior.

Strategies

11.2.1. Assess the type of information currently collected.
11.2.2. Determine the appropriate data variables to be collected.
11.2.3. Emphasize consistent coding of injury by utilizing the categories included in the International Classification of Diseases.
11.2.4. Provide rationale and incentives for utilizing specific methodologies for collecting uniform data.

Objective 11.3. Produce a bi-annual report on suicide and suicide attempts.

Strategies

11.3.1. Identify available and appropriate data sources.
11.3.2. Synthesize data from multiple data management systems including but not limited to law enforcement, emergency medical, public health departments, and hospitals.
11.3.2. Produce and disseminate a report to legislators, state agencies and public and private organizations.

Texas Suicide Prevention Plan Steering Committee

*(Note: The Steering Committee finished its work with the development of the Texas State Plan for Suicide Prevention and ceased as an ad hoc group. Work affiliations have changed for some of the individuals listed. Many of the original members remain involved in suicide prevention activities through the Texas Suicide Prevention Partnership (a subcommittee of the Texas Strategic Health Partnership) sponsored by the Texas Department of Health. (**http://www.tdh.state.tx.us/**). Other individuals have become involved in forming local suicide prevention coalitions across the state. The Texas Suicide Prevention Community Network is a network of these local coalitions sponsored by the Mental Health Association in Texas (**http://www.mhatexas.org**).*

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Membership on the committee or contribution to the plan does not imply agreement or endorsement of the plan by the respective agencies or organizations.